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## ABSTRACT

Four developmental outcomes of children's play were identified as acquaintance with the environment and the development of cognitive activity, verification of incidental learning, the development through sensory and motoric activities of relationships with objects and persons, and experience with roles and rules. A child developing atypically may not have gone through these stages or may have deficient adapting or coping skills; often he or she is nonverbal. The nonverbal child's failure to communicate may be one of the causes for failure to play (or vice versa), or both failures may be due to another factor. The basis of therapeutic intervention with the nonverbal child is the identification and utilization of the child's strengths. Approaches devised for the mentally retarded are appropriate for use with other nonverbal children. A sequence of play therapy which varies structured and unstructured conditions across play materials and therapeutic interactions, and which progresses from totally unstructured to entirely structured conditions, can be employed to good effect. Emphasizing the child's sense of self and interaction with the therapist in the context of play activities and providing clearly defined rewards and punishments, has been used to produce a level of speech readiness at which the nonverbal child can benefit from speech therapy. (RH)

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### Play Therapy with the Nonverbal\*

Since the general theme of this symposium is communicating with nonverbal individuals, I will first approach the issues of psychotherapy or more specifically play therapy that emerges in this group. We have to recognize that the nonverbal individual not only presents a specific problem in communication but also in terms of the basis of the nonverbal behavior, presents various problems in the general aspects of brain growth and personality development. Typically, people don't talk either because there is a breakdown in the mechanism, or there are central processing problems of physiological or emotional origin or both. Here we are considering individuals who should be talking (the mechanisms are in order) but who, for some reason, are not.

Since the human animal is distinguished by the fact that it cognizes; that this power of cognition is a "history making" power; and that it is historically demonstrated by the fact that it is also a language-bearing animal; the fact that speech has failed indicates some kind of major slippage in the normal course of individual development. Such an individual has to be described as an atypically developing person. Atypical development is never centered in one single sphere, but usually involves a large number of related areas of growth and development.

While this may seem to be an obvious point it becomes an important one for clinicians because all too often parents will bring children into a therapeutic setting with the statement "If she could only speak, everything else would be fine." This is much like the midwestern farmer saying if it would only rain, he would have a good crop. Unfortunately, we don't have

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that kind of one-to-one relationship. If we were not dealing with atypical growth and development, the child probably would speak. Since we are dealing with atypical growth and development, (1) the child isn't speaking and (2) a number of other problems exist.

Moving to a consideration of play, we recognize that play activity is so described by adults because it seems to be productless activity and one seems to differentiate between something called work, which has a product, and play, which doesn't. However, for the child play has a very definite product and therefore we typically describe play as the "manner in which the child works." There are essentially four products which can be identified from this play. The first is acquaintance with the environment and the development of active, cognitive activity. It is through play that the child literally learns to accommodate the objects and cues within the environment and begins to assimilate them so that there is a major perceptive product emerging from this activity. Typical behavior at this level is moving to get an object from around a barrier, or looking around for the object, peering over the edge of the crib, or a chair or some other place for a lost object, visually following people when they have disappeared or objects when they roll under the table, etc., and it is this type of activity which leads to the development of appropriate spatial relationships which helps establish within the infant a concept of their place within the rest of the environment. Second, play also has the role of verifying incidental or accidental learning. Thus, the child will play in an exploratory manner, pounding and hammering on things, emptying and filling containers, stacking and unstacking objects, rolling and bouncing, pushing and pulling, scribbling, digging and piling, building and knocking down, amassing and

organizing, all in the process of exploring the environment and verifying whatever learning has been derived. Third, the children will begin to move into a relationship type of play involving both sensory and motoric activities, objects will be put regularly into the mouth, they will bat with their arms or hands, begin to shake noisy things, attempt to touch another person's face or clothing or hair, objects will be banged together, things will be intentionally thrown with the expectations if another person is present that they will be thrown back, peek-a-boo and patty-cake become preferred games, all in an add mixture of sensory and motoric behavior to gain further insight into the interactive relationship of things. And fourth, with the older child we begin getting play which also verifies learning from other sources. This moves into aspects of imaginative play, the use of fantasy, playing house, pretending to be father or mother, pretending that an object is something else (a stick becomes a car or a rock becomes a space ship)--the general pattern of primitive imaginative play where the child is in effect testing the kinds of information previously obtained from adult relations. The highest level, in fact, of this type of play is where the child pretends to be an adult with whom there is a relationship over and above pretending to be mother or father. They may begin to assume the role of a doctor or another kind of person who may be a frequent visitor or someone with whom they are in regular contact including characters seen regularly on T.V. This moves to a level of social play both with adults on one hand and with other children on the other and here the socio-dramatic aspects of the play take on very "dramatic" forms and what was previously merely pretending to be someone suddenly takes on the total enactment of the whole scene. You have the playing of TV stories or home events. The child then moves into play activities which have very specific and clearly defined rules. These may

start with simple board games or card games, moving on into major group games such as tag or blind man's bluff, or socio-dramatic play which has very specific rules. A cop is a cop and a robber is a robber, the roles are fixed and there are certain things that are supposed to happen on each side.

These are some of the steps typical of expected play development. One would anticipate that most children will follow these patterns, if not in order, at least touching those kinds of bases. These patterns are fairly generalized and one finds very similar kinds of play growth activities across cultures. This process of becoming acquainted with the environment, testing it, getting insights and testing adult teaching seems to exist throughout most areas of child growth and development within somewhat the same form, so that different cultures, east, west, north and south, show up with many of the same kinds of games which seem to have the same "work" relationship to the child playing them.

Now with that kind of background, when we speak of a child developing atypically we are saying in effect, (1) that the child may have not learned to play, meaning he hasn't gone through the phases that I just described and (2) that there is probably something very wrong with this child's adaptive coping skill because such a child will also almost inevitably have major problems dealing with the stimulus material from the environment and there will be great problems in receiving the stimulus material in the expected way, there will be even greater problems in perceiving what has been received and one would expect major apperceptive errors. ~~(I realize that Dr. Sternlicht will be touching on this area as it relates to projective testing in the next paper so I won't deal with that aspect any further.)~~ Since this whole aspect of the cognitive development of the child is severely affected by the

child's failure to play, we in a sense are starting very close to square one when the child comes into play therapy.

Now to take an aside, this child is often nonverbal. That means that the difficulties are even greater and the developmental and growth failures are even more intense. It also means that those aspects of life's experiences which depend on communication exchanges have not occurred and we have a variety of additional learning deficits. It is hard to define the exact nature of these additional deficits because one cannot assign cause to a specific deficiency but we must recognize that the failure to communicate may be one of the causes for the failure to play or vice versa or that both of them may be due to a third element which has not been defined by our behavioral observations. We find that our first necessity is to try to discover what it is that the child can do and in the area of play therapy what types of play activities are most responsive--where in other words are the "hills" or areas of strength, because it is absolutely necessary that the child be approached in terms of the strengths, recognizing that the weaknesses or "valleys" are there because of specific errors in development. Emphasis on the "valleys" would only increase the frustrations, further disturb the personality development and make therapy both a painful and probably an unsuccessful task.

The usual approaches to play therapy with the mentally retarded are very appropriate. Based originally on my work with Dan Smith in Parsons, Kansas and more recently with Marilyn Deutsch in Scranton, Pennsylvania we have identified four types of play therapy approaches based primarily on the manipulation of structure. These approaches are (1) Unstructured materials and Unstructured therapeutic approach (U-U); (2) Unstructured materials and Structured therapeutic approach (U-S); (3) Structured materials and Unstructured therapeutic approach (S-U) and (4) Structured materials and

and Structured therapeutic approach (S-S). The nonverbal child is brought first into the U-U level of play. The unstructured therapeutic approach does not imply the lack of goals, in fact to the contrary the therapist has some very major goals which are centered around developing within the child a sense of self, developing some ability to relate to objects in a playful manner and developing some means of interpersonal contact which is generally the first step toward communication. If, as sometimes occurs, the child demonstrates all of these abilities in this first play session, the therapist immediately moves to the U-S level which sets up a much more structured play activity where the child is expected to use the materials in a more structured manner. Here the emphasis is a little bit more on an end product and the types of activities are those which are typically associated, for example, with art therapy or music therapy. Again the emphasis is on the child's sense of self and the interaction with the therapist utilizing the play activities as the basis of this interaction. The play therapist is not a speech therapist and no specific efforts are made to induce verbal activity, but since the primary basis of any kind of play therapy is that the child gain a certain amount of insight, verbal activity is required. What emerges is a pattern of "forcing the child to think." That is, the child elects to carry out certain behaviors. The therapist then tries to obtain from the child some indication that the child is aware of what is being done. This indication, since we are dealing with a nonverbal child, is through some kind of gesture or, more often, when the therapist makes a suggestion as to what is occurring the child will agree to the suggestion. If on the other hand the therapist is completely ignored, and his suggestion as to the title of the activity such as "You are digging a hole, aren't you?" is completely ignored, the therapist intrudes. The child finds suddenly that

playing has stopped and the therapist interjects that "You were digging a hole, weren't you?" and indicates that some kind of response is required, if it is only eye contact.

Eventually children learn that in order to get the therapist off their backs, they are going to have to respond. Once this is achieved, the child suddenly discovers freedom to play and the therapist's intrusions are removed. This is true at the U-U level, as well as the U-S level or at higher levels if the child is capable of reaching them. This operation introduces cognitive activity at its most primitive form and becomes therapeutic in the sense of the child discovering that they have some influence and some responsibility in relationship to what is happening. Further they learn that the things they do are acceptable as long as they know what they are doing and that the therapist will go along with them and play with them if they will make some indication that that is the way they want to play.

This is a procedure that is used routinely at the Nisonger Center and other centers where play therapy with the mentally retarded is a standard treatment process. It is based on the manipulation of structure both in terms of the materials and in terms of the approach of the therapist and this manipulation of structure leads, if properly handled, to the child developing some type of cognitive involvement. When this is present there is a clearly defined reward in the form of being permitted to choose their own play activity. When it is not present there is a clearly defined punishment in the form of being intruded upon and being prohibited from choosing their own activity. Since the right to choice is the predominant movement force and the choice itself is usually based on already identified "hills," this means that their voluntary activity is something they already feel they can do--that when they are allowed to do it they attain a success on

their level and the therapy is able to move forward.

Now this is obviously much to short an exposition of what goes on in play therapy. I have tried to present the broad lines of the situation in keeping with the previous description of the problems surrounding play and at this point it is best to say that the nonverbal child responds very well to this kind of situation because while some communication demands are being made, there is a process of ongoing reward for nonverbal communication which is often lacking in the child's normal environment. It is our experience then that if these "hills" are properly developed, the "valleys" have a tendency to grow and that the child does in fact begin mimicking the therapist's speech. The child further introduces noises into the therapy session which the therapist in turn mimics so that the child begins to get an impression of some kind of communication. This is verified because we find the child sometimes reacting very violently to the therapist's imitation in the sense of saying, "No that's not what I was trying to say," and as it moves ahead we produce a level of speech readiness which makes it possible for communication specialists to pick up on a broader level. Further, if the child is in an education setting where they can learn sign communication, this is carried over into the play therapy situation so that there is no issue of a child communicating in one training setting but being unable to do so in another. While it is very important that the child recognize the difference in setting and understand that a play setting is not a classroom, where skills are learned, they should be able to be generalized and be carried over from one setting to another and we make sure that this can occur.

In closing I have tried to describe the role of play itself in growth and development, also to point out the relationship between this and the atypical developing child in play therapy, and have briefly outlined a method whereby we can ameliorate this situation, leading to a better opportunity for interpersonal and social communication.